



St. Thomas School

FORM A
Required Immunizations
Eff. 2016/2017

St. Thomas the Apostle School Health Office . 42 Adams Place · Delmar, NY 12054 . (518)439-5573 Phone · 518-478-9773 fax

Please ask your child's doctor to complete this form and sign below or attach a signed copy of the physician's immunization record.

Preschool	Kdg. – Gr. 2	Grades 3– 5	Grade 6	Grade 7-8
DTaP – 4 doses IPV – 3 doses MMR – 1 dose HepB – 3 doses Varicella – 1 dose Hib – 1 dose PCV – 1-4 doses: PCV13- 1 dose (Age 4-5) Tdap – n/a Lead screening blood test	DTaP – 5 (4) doses: (unless the 4 th dose is received at 4 years of age or older). IPV – 4 doses: 4 th dose between age 4-6 MMR – 2 doses HepB – 3 doses Varicella – 2 doses Hib – n/a PCV – n/a Tdap - n/a	DTaP – 5 (4) doses: (unless 4 th dose is received at 4 years of age or older). IPV – 3 doses MMR – 2 doses HepB – 3 doses Varicella – 1 dose Hib – n/a PCV – n/a Tdap – (May have Tdap after age 7)	DTaP – 3 doses Tdap – 1 dose IPV – 4 doses: (unless 3 rd dose received at 4 years of age or older) MMR - 2 doses HepB – 3 doses Varicella – 2 doses Hib – n/a PCV – n/a	DTaP – 3 doses Tdap – 1 dose IPV – 4 doses: (unless 3 rd dose received at 4 years of age or older) MMR – 2 doses HepB – 3 doses Varicella – 2 doses Hib – n/a PCV – n/a **Meningococcal Vaccine – 1 dose required for 7th grade entrance

St. Thomas the Apostle School requires proof of compliance with this law at the time you register your child. **Adequate proof** includes a **written certificate or record from the physician's office, a transcript from the previous school, or a certificate of religious or medical exemption.**

If the immunizations have not been completed by the date your child is to enter school, **we must exclude the child from school** until the immunizations have been completed or until proof of satisfactory progress toward the completion is shown. Please be advised that the law requires us to exclude children for up to two weeks if the process is not taking place and that, after two weeks of exclusion, we are required to notify Child Protective Services, a division of Albany County Department of Social Services.

Student Name (last, first):	Date of Birth:	Grade Entering:
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Immunizations	Date	Date	Date	Date	Date
IPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
DTaP	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Tdap	___/___/___	___/___/___			
Measles	___/___/___	___/___/___			
Mumps	___/___/___	___/___/___			
Rubella	___/___/___				
MMR	___/___/___	___/___/___			
Hepatitis B	___/___/___	___/___/___	___/___/___		
Varicella	___/___/___	___/___/___	History of Disease on:		___/___/___
HIB	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Pneumococcal (PCV)	___/___/___	___/___/___	___/___/___	___/___/___	PCV13 ___/___/___
Meningococcal	___/___/___	___/___/___			

Lead Screening Blood Test: Date _____ Results: _____

Physician's Signature:	Date:
Physician's Name/Stamp:	